STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUII	A. BUILDING		COMPL	ETED
		155523	B. WIN			08/23/2	011
			-		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t .		5911 W	STATE RD 46		
	ND BEAN BLOSSO	M HEALTH CARE CENTER			TSVILLE, IN47429		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0000							
	This visit was fo	r the Investigation of	FO	000	Preparation and/or execution	n of	
	Complaint IN000	_			this plan of correction in gen		
	Complaint II voor	074701.			or this corrective action does	not	
	Commissing INTOO	004001 Cubatantists J			constitue an admission or		
	•	094981-Substantiated.			agreement by Richland Bear		
		ficiencies related to the			Blossom Health Care Center		
	allegation are cit	ed at F-333 and F-425.			the facts alleged or conclusion set forth in this statement of	J115	
					deficiencies. The plan of		
	Survey dates: 08	8/22/11 and 08/23/11			correction and specific corre	ctive	
					actions are prepared and/or		
	Facility number:	000558			executed in the compliance		
	Provider number				the state and federal laws.Pl		
	AIM number:	100267550			accept this plan of correction constitues our credible allegations.		
	THIN HAIROUT.	100207330			of compliance with all regula		
	Cumurari taamai				requirements.This plan of	tory	
	Survey team:	DN			correction also comes to you	ı as a	
	Sharon Whitema	in, KN			request for a desk review du		
					the scope and severity of the		
	Census bed type:	•			alleged deficiencies in this s		
	SNF/NF: 73				and supportive documentation	on is	
	Total: 73				being attached exemplifying compliance and on going		
					monitoring to assure complia	ance	
	Census payor typ	oe:			is maintained	-	
	Medicare: 07						
	Medicaid: 44						
	Other: 22						
	Total: 73						
	101.1. /3						
	Sample: 03						
	These deficiencie	es also reflects state					
	findings cited in	accordance with 410 IAC					
	16.2.						
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		ITITLE		(X6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4ZPW11

Facility ID:

000558

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155523	B. WING				
	OVIDER OR SUPPLIER BEAN BLOSSON	Л HEALTH CARE CENTER		5911 W	ADDRESS, CITY, STATE, ZIP CODE STATE RD 46 TSVILLE, IN47429		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Quality review co	ompleted on August 25, lkner, RN					
SS=D fr E F F R O f R b n r p h	ree of any significations are actility failed to explosician's discharged for medications are medications are medications and 10 discharged for medications and 10 discharged for medications are medications and 10 discharged for medication and the medica	arge orders were g in 1 of 3 residents lications not receiving as ordered for a period of days. (Resident A) ent A's clinical record on a.m., indicated the iagnoses which included, ted to, hypertension, andent diabetes, acute hyperkalemia (high erate pulmonary	F0	333	F 333 Resident Free of Significant Medication Errors facility strives to assure resid are free of significant medical errors:Corrective Action take Resident A:Resident A's physician reviewed and signed the resident's medication orders 3/12/2011 following the return from the hospital, which inclusion order for Alprazolam 0.25 1 tablet) twice a day.On 8/24/2011 Resident A's physician medication dos reduction trial of the resident' dose Alprazolam 0.25mg twice daily to once daily at bedtime.Identification and corrective actions for others appotential to be affected:All resident's have the potential hospital discharge instruction facility physician order discrepancy. Hospital dischar instructions and facility physicians orders were reviewed of curriculated residents experiencing a readmission in the last three months, to assure orders correlate or there is appropriated ocumentation of physician notification and order (s)	ents tion n for sician on n ded mg (ician e 's low ce with for n and rge cian ent	09/08/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	ETED
		155523	B. WIN			08/23/20)11
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	R		1	STATE RD 46		
	ND BEAN BI 0660	M HEALTH CARE CENTER		1	ΓSVILLE, IN47429		
RICITLA	ND BEAN BLOSSO	WITHEALTH CARE CENTER		ELLETT	13VILLE, 11147429		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re l	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	needs to have a l	BM [bowel movement].			received. Upon review no otl	ner	
	Assisted to BR [bathroom] by CNA c			discrepancies have been		
	[with] 0 [no] BN	M. Assisted to bed."			identifiedMeasure to prevent		
	[[[[[[[[[[[[[[[[[[[[11.11.11.11.11.11.11.11.11.11.11.11.11.			recurrence:Licensed nursing	starr	
	A myumaala mata d	oted 02/06/11 at 11:45			education was provided on 8/25/11 regarding reconciling	,	
	· ·	ated 03/06/11 at 11:45			hospital discharge instruction		
	1 *	'This nurse went to check			and documentation of physic		
	on Res. Res in b	ped, diaphoretic			notification and orders as given		
	[sweating] c/o a	bd [abdominal] et			by the resident's facility		
	epigastric pain.	B/P [blood pressure]			physician.Two nurses will rev	view	
		140, R [respirations] 24,			readmission orders and sign	the	
		ituration] 94% RA [room			orders confirming review of		
		= =			hospital discharge orders wit		
		ded [sic] to vomit brown			facility orders. How will the fa	acility	
	liquid. Order red	ev'd [received] to send			monitor and who is		
	Res to ER [Emer	rgency Room] for eval			responsible:The Director of		
	[evaluation]."				Nursing is responsible for assuring residents are free for	om	
]				significant medication errors		
	Δ nurse's note (no date or time) indicated,			including assuring document		
	· ·	-			of physician notification and		
		cy Services] @ bedside.			implementation following hos		
		es transported to (local			readmission. The Director of		
	hospital)"				Nursing or her designee will		
					monitor, physician orders of		
	A nurse's note, d	ated 03/07/11 at 6:00			residents readmitted from the	e	
	· ·	"Notified by Hosp			hospital, to assure hospital		
		Resident A] admitted to			discharge orders are		
		_			implemented in accordance		
		[diagnoses] hypotension,			the resident's physician orde Monitoring of physician	rs.	
	hyperkalemia, re				readmission orders will be		
	[insufficiency]	."			completed on		
					resident readmissions for 90	days	
	A nurse's note. d	ated 03/10/11 at 1:30			and then once a month on ea		
	p.m., indicated, '				nursing unit. Results of this		
	1 ~	na noted, pedal pulses +			monitor will be reviewed by t		
	1 *	ia noteu, peuai puises +			Administrator and reported a	t	
	[present]"				least quarterly to the Quality		
					Assurance committee.Date of	of	
	Hospital dischar	ge orders, dated 03/10/11,			Completion: 9/8/11		

l	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155523		ĺ	IULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE : COMPL	ETED
		100023	B. WIN			08/23/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE STATE RD 46		
		M HEALTH CARE CENTER			SVILLE, IN47429		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ΤE	COMPLETION DATE
_		which included, but were		_			
		lprazolam (anti-anxiety					
	medication) 0.25	milligrams to be given					
	every 6 hours as	needed.					
	A physician's pro	ogress note, dated					
	1	ed the resident had					
	· ·	icility from the hospital					
	and hospital disc	harge orders were to be					
	followed.						
	A March. 2011 "	Medication Record"					
	1	er, dated 01/28/11, for					
		milligrams to be given					
	twice daily. Afte	er the resident returned to					
	1 -	/10/11, the resident					
		ing 0.25 milligrams of					
	1 ^	e daily as routine					
	medication.						
	A physician's re-	write order for August,					
	2011, indicated F	Resident A continued to					
	receive Alprazola	am 0.25 milligrams (1					
	tablet) twice dail	y.					
	Interview of the	DON [Director of					
		22/11 at 12:55 p.m.,					
	indicated she had	d only been at the facility					
		and the previous DON					
	-	vith all PRN (as needed)					
	1	ications. The DON					
	1 ^	vious DON wouldn't					
		anxiety medications in the					
	facility.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S A DUIL DING 00 COMPLE					
		155523	A. BUIL B. WING			08/23/2	
	PROVIDER OR SUPPLIER	и HEALTH CARE CENTER		5911 W	DDRESS, CITY, STATE, ZIP CODE STATE RD 46 SVILLE, IN47429		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
F0425 SS=D	This Federal/Stat Complaint IN000 3.1-25(b)(9) 3.1-48(c)(2) The facility must pemergency drugs residents, or obtain described in §483. facility may permit administer drugs if under the general nurse. A facility must proviservices (including accurate acquiring administering of all meet the needs of the facility must e of a licensed pharm consultation on all pharmacy services. Based on record revised facility fair system in consultant services are services are services are services.	rovide routine and and biologicals to its in them under an agreement 75(h) of this part. The unlicensed personnel to 5 State law permits, but only supervision of a licensed procedures that assure the interest in procedures that assure the interest interest in procedures that assure the interest interest in procedures that assure the interest interest interest interest interest interest interest interest in the facility. Interview and interest intere	FO	425	F 425 Pharmaceutical ServicesRichland Bean Bloss has contracted pharmacy consultant services and nurs personnel review and reconc changes in medication orders. Action taken for reside A:8/24/2011 Resident A's physician implemented medication dose reduction trithe resident's low dose Alprazolam 0.25 mg twice da once daily at	som ing iile ent	DATE 09/08/2011
	personnel	were			bedtime.ldentification and corrective actions for others we potential to be affected:All		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	155523		LDING	00	COMPLETED 08/23/2011	
		100020	B. WIN		ADDRESS STELL STATE STR SODE	00/23/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE STATE RD 46		
RICHLAN	ND BEAN BLOSSO	M HEALTH CARE CENTER		1	TSVILLE, IN47429		
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID	- , - <u>-</u>	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	ON
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	reviewing	and			residents have the potential hospital discharge instruction	l l	
	reconciling changes in				and facility physician order discrepancy. Review of the		
		•			hospital transfer orders and		
	medicalio	n orders to			facility physician orders was	ata	
	ensure Me	edication			completed, of current reside experiencing a readmission		
	Administration Record				past 3 months, to assure physician orders correlate or	l l	
	and Physi	cian orders			appropriate documentation of physician notification and ord		
	were accu				(s) received.No other		
	were accu	rate. Tills			discrepancies have been notified.Measures to prevent	:	
	resulted in	n (Resident A)			recurrence:Licensed nursing education was provided on		
	not receiv	ing			8/25/2011 regarding reconcil	ing	
	medication	ns as ordered		readmission orders and documentation of physician			
	by a physi	ician for a			notification and orders as given by the resident's facility	ren	
		5 months and			physician. Two nurses will re readmission orders and sign		
	period or .	J monuis and			orders confirming review of		
	10 days.				hospital discharge orders with	:h	
	,				facility orders.Consultant pharmacist was notified of ci	tation	
					to promote awareness of this		
	Findings I	include:			issue and increase diligence	l l	
	<i>O</i>				medication review.How will t facility monitor and who is	ne	
	Review of Resident A's clinical record on 08/22/11 at 10:12 a.m., indicated the following:				responsible:The Director of		
					NUrsing is responsible for		
					assuring residents are free fi significant medication errors		
					including assuring document		
					of physician notification and		
					transcription of orders to be implemented following hospi	tal	
					readmission. The Director of		
					Nursing or her designee will		

NAME OF PROVIDER OR SUPPLIER RICHLAND BEAN BLOSSOM HEALTH CARE CENTER RESIDENT (BACH DEFICIENCY MUST BE PERCEDED BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL PROPE BY PELL PROPERLY (BACH DEFINITION OF A MUST BE PERCEDED BY PELL BY A MUST BE PERCEDED BY A MUST BE PERCED	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER RICHLAND BEAN BLOSSOM HEALTH CARE CENTER IXI SUMMARY STATEMENT OF DEFICIENCIES (BACH DEFICENCY MUST THE PERCEIDED BY PULL). TAG (BACH DEFICENCY MUST THE PERCEID BY PULL). TAG (BACH DEFICENCY MUST THE PROVIDED BY TAG (BACH DEFICENCY MUST THE PROVIDED B	AND FLAN	OF CORRECTION				00	
RICHLAND BEAN BLOSSOM HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DETICENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH DEFICIENCY MUST BE PERCED TO COMPLETED BY FULL TAG (EACH DEFICIENCY MUST BE PERCED TO COMPLETED BY FULL TAG (EACH DEFICIENCY MUST BE PERCED TO COMPLETED BY FULL TAG (EACH DEFICIENCY MUST BE PERCED TO COMPLETED BY FULL TAG (EACH DEFICIENCY MUST BE PERCED BY FULL TAG (EACH DEFICIENCY MUST BE PERCED BY FULL TAG (EACH DEFICIENCY MUST BY FULL TAG (EACH DEFICIENCY MUST BY FULL TAG (EACH DEFICIENC				B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
SUMMARY STATEMENT OF DEFICIENCIES TAG	NAME OF P	PROVIDER OR SUPPLIER			5911 W	STATE RD 46	
Resident A had diagnoses which included, but were not limited to, hypertension, non-insulin dependent diabetes, acute renal failure with hyperkalemia, moderate pulmonary hypertension, and dementia. A nurse's note, dated 03/06/11 at 11:30 p.m., indicated, "Res [Resident A] @ nurse's station c/o [complained of] epigastric pain. States she is sick et [and] needs	RICHLAN	ND BEAN BLOSSON	M HEALTH CARE CENTER		ELLETT	ΓSVILLE, IN47429	
Resident A had diagnoses which included, but were not limited to, hypertension, non-insulin dependent diabetes, acute renal failure with hyperkalemia, moderate pulmonary hypertension, and dementia. A nurse's note, dated 03/06/11 at 11:30 p.m., indicated, "Res [Resident A] @ nurse's station c/o [complained of] epigastric pain. States she is sick et [and] needs	1 1						` ′
Resident A had diagnoses which included, but were not limited to, hypertension, non-insulin dependent diabetes, acute renal failure with hyperkalemia, moderate pulmonary hypertension, and dementia. A nurse's note, dated 03/06/11 at 11:30 p.m., indicated, "Res [Resident A] @ nurse's station c/o [complained of] epigastric pain. States she is sick et [and] needs		*				CROSS-REFERENCED TO THE APPROPRIA	TE
	IAU	Resident A diagnoses included, I limited to, non-insuli diabetes, a failure with hyperkales pulmonary and demend A nurse's 103/06/11 a indicated, A] @ nurse [complain epigastric she is sick	A had which but were not hypertension, n dependent acute renal th mia, moderate y hypertension, ntia. note, dated at 11:30 p.m., "Res [Resident se's station c/o ed of] pain. States tet [and] needs		IAU	monitor physician orders of residents readmitted from the hospitalto assure hospital discharge orders are implemented in accordance the resident's physician order Monitoring of physician readmission orders will be completed on readmissions days, and then ongoing monitoring of one readmission from each unit each month. The results of monitoring will be reviewed by the facility Administrator and reported a least quarterly by the Quality Assurance Committee. Date	e with ers. for 90 on The

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155523			ULTIPLE CO LDING	onstruction 00	(X3) DATE SURV		
		155523	B. WIN			08/23/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE STATE RD 46		
RICHLAN	ND BEAN BLOSSOI	M HEALTH CARE CENTER		ELLETT	ΓSVILLE, IN47429		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ULD BE COMPLE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE .	DATE
	movemen	t]. Assisted to					
	BR [bathr	oom] by CNA					
	c [with] 0	[no] BM.					
	Assisted to	o bed."					
	A nurse's	note, dated					
	03/06/11 a	at 11:45 p.m.,					
	indicated,	"This nurse					
	went to ch	neck on Res.					
		d, diaphoretic					
	[sweating]] c/o abd					
	[abdomina	al] et epigastric					
	pain. B/P	[blood					
	pressure]	66/34, P					
	[pulse] 14	0, R					
	[respiration	ons] 24, SP02					
	oxygen s	aturation] 94%					
	RA [room	air]. Res					
	preceeded	[sic] to vomit					
	brown liq	uid. Order					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPLE		
		155523	A. BUI B. WIN	LDING IG		08/23/20)11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE STATE RD 46		
RICHLAN	ND BEAN BLOSSO	M HEALTH CARE CENTER		1	ΓSVILLE, IN47429		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO 1		.TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	\(\(\) \(\)	DATE
	recv'd [received] to send						
	Res to ER	[Emergency					
	Room] for	r eval					
	[evaluatio	n]."					
	A nurse's	note, (no date					
	or time) ir	ndicated, "EMS					
	Emergen	cy Services] @					
	_	Report given.					
	Res transp	oorted to (local					
	hospital)						
	1 /						
	A nurse's	note, dated					
		at 6:00 a.m.,					
		"Notified by					
		•					
	Hosp [hos	• -					
	-	A] admitted to					
	Rm [room	-					
	[diagnoses	s] hypotension,					
	hyperkale	mia, renal					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155523		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	CON	TE SURVEY MPLETED 3/2011	
	PROVIDER OR SUPPLIER	M HEALTH CARE CENTER		STREET A	DDRESS, CITY, STATE, ZIP COI STATE RD 46 SVILLE, IN47429	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	_	sufficiency]"					
		note, dated					
		at 1:30 p.m., "Res returned					
	,	0 edema					
	_	lal pulses +					
	[present]	1					
	[present]	•••					
	indicated included, limited to (anti-anxiou) 0.25 milli	lischarge ted 03/10/11, orders which but were not Alprazolam ety medication) grams to be ry 6 hours as					
	A physicia	ans's progress					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155523		LDING	NSTRUCTION 00	(X3) DATE COMPI 08/23/2	LETED	
	PROVIDER OR SUPPLIER	M HEALTH CARE CENTER	STREET A	ADDRESS, CITY, STATE, ZIP CODE STATE RD 46 TSVILLE, IN47429		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	note, date	d 03/12/11,				
	indicated	the resident				
	had return	ed to the				
	facility fro	om the hospital				
	and hospit	tal discharge				
	orders we	re to be				
	followed.					
	A March,	2011				
	"Medicati	on Report"				
	indicated	an order, dated				
	01/21/11,	for Alprazolam				
	0.25 milli	grams to be				
	given twice	ce daily. After				
	the resider	nt returned to				
	the facility	y on 03/10/11,				
	the resider	nt continued				
	receiving	0.25				
	milligram	s of				
	Alprazola	m twice daily				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155523		LDING	NSTRUCTION 00	CO	TE SURVEY MPLETED 3/2011	
	PROVIDER OR SUPPLIER	M HEALTH CARE CENTER	5911 W	DDRESS, CITY, STATE, ZIP C STATE RD 46 SVILLE, IN47429	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	as routine	medication.				
	A physicia	an re-write				
	order for A	August, 2011,				
	indicated	Resident A				
	continued	to receive				
	Alprazola	m 0.25				
	milligram	s (1 tablet)				
	twice dail	y.				
		of the DON				
	-	of Nursing] on				
		at 12:55 p.m.,				
	indicated	she had only				
	been at the	e facility about				
	3 months	and the				
	previous I	OON had done				
	away with	all PRN (as				
	needed) as	nti-anxiety				
	medicatio	ns. The DON				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155523		(X2) MULTIPLE CONSTRUCTION OO A. BUILDING			X3) DATE SURVEY COMPLETED	
			A. BUI B. WIN			08/23/20	011	
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE STATE RD 46			
RICHLAND BEAN BLOSSOM HEALTH CARE CENTER				1	ΓSVILLE, IN47429			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	DATE	
	indicated the previous DON wouldn't allow							
	PRN anti-anxiety							
	medications in the							
	facility, th	erefore						
	Resident A	A's Alprazolam						
	order was	not changed to						
	PRN as ordered by							
	physician.							
	A Consult	ant pharmacy						
	report for the dates of March 01,2011 through March 19, 2011 was							
	<i>^</i>	by the DON						
	•	•						
		at 12:00 p.m.						
	•	rt indicated						
	there were							
	irregularit	ies found for						
	Resident A	A's medication						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155523	A. BUILDING 00 CO. 08/2		(X3) DATE S COMPL 08/23/20	ETED		
NAME OF PROVIDER OR SUPPLIER RICHLAND BEAN BLOSSOM HEALTH CARE CENTER			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE S911 W STATE RD 46 ELLETTSVILLE, IN47429					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	during this time period.							
	Resident A returned to							
	the facility on 03/10/11							
	with new discharge							
	orders from	m the hospital.						
	Pharmacy	personnel and						
	nursing personnel failed							
	to recognize the change							
	in orders for the							
	Alprazolam beginning							
	3/10/11 and the resident							
	continued to receive the							
	Alprazolam twice daily							
	as a routin	ne medication.						
	This Fede	ral/State tag						
	relates to	Complaint						
	IN000949	81.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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ll i		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155523	(X2) MULTIPLE A. BUILDING B. WING	00		E SURVEY PLETED 2011		
NAME OF PROVIDER OR SUPPLIER RICHLAND BEAN BLOSSOM HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5911 W STATE RD 46					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	3.1-25(i)	ESC IDEATH FING INFORMATION)						